DATE: October 27, 2015

TO: IIPRC Management Committee

FROM: Industry Advisory Committee

SUBJECT: IIPRC Group DI Standards Dated August 14, 2015

We are submitting the following comments:

Re: Policy/Certificate Standards

Response to August 14, 2015 Comments Submitted by the IIPRC Consumer Advisory Committee (CAC) Re: Page 52, Item (B) (1) Previous Item (m) "Reduction on Account of Other Benefits or Income" "Third Party Settlements"

This letter contains several inaccuracies which we will address.

The CAC letter contends that the Industry Advisory Committee advocated for a third party settlement offset as a "***new Proposed Standard***". This offset has been in the group DI marketplace for some time and companies have had this filed and approved for use, which is why we advocated to include it in the IIPRC standards.

The CAC letter further contends that we had refused to substantiate the approval records for this offset. To the contrary, on May 12, 2015, in the comments we submitted to the IIPRC and which became public records, we stated "We wish to advise that this offset is currently approved in all states except Missouri, New Jersey and North Carolina." When we provided this information to the Product Standards Committee (PSC), the PSC and the IIPRC staff were able to substantiate this, which is probably why the offset is currently a proposed standard.

The CAC letter contends that the offset violates state subrogation laws as well as not conforming to subrogation "made whole" laws and destroys the long-established consumer protections in this area.

We would first like to note that some group disability policies contain subrogation as well as third party recovery provisions. Group disability income insurance is provided at the option of the group insurance purchaser (typically employers). Coverage is not mandatory, and purchasers look to provide affordable and quality income protection insurance offering peace of mind to employees. It is important to note that neither subrogation nor third party recovery provisions are implicated unless benefits are payable under a group disability policy. In such a circumstance, a claimants' income stream is protected while the overall cost of the group disability coverage is also mitigated.

The "made whole" doctrine is the equitable principle applied in subrogation claims that, ***unless the parties contract otherwise***, an insurer will not receive proceeds from a claim settlement unless settlement funds exceed full compensation for all loss. It is common for carriers to assert a subrogation right or claim when it appears that a third party may have caused a claimant's disability. Whether the "made whole" doctrine applies depends on a number of factors, including whether state or federal law applies, whether the claimant or counsel has made an assertion that the claimant has not been made whole, as well as the specific terms of the underlying policy or a subrogation provision within a specifically negotiated contract. If the policy enables an offset this would not run afoul of the make whole doctrine. This is especially pertinent in disability income policies where the intent is not to make an individual whole from all harm, rather to provide a level of income protection that still provides an incentive to return to work if possible.

Alternatively, third party recovery provisions are reimbursement provisions, not subrogation provisions. Third party recovery offset provisions allow for the reduction of disability benefits that are owed to an insured by the prorated amount of settlement or judgment proceeds that the insured receives from the third party that allegedly caused the insured's disability. These provisions offer insurer's limited protection, because claimants' counsel can often craft settlements that avoid offset in a disability policy. Additionally, these provisions avoid unnecessarily delay and protract litigation involving claimants and insurers thereby increasing the cost to both (cost that would ultimately be reflected in cost of coverage).

It should be noted that Group DI premiums take into account the probability that the benefits selected by the employer will be subject to various offsets, and the premium is thus more affordable enabling the employer to offer the plan to employees. A Group DI plan with no offsets would be cost prohibitive, and to our knowledge there is no such plan in the marketplace today, for cost reasons.

While we agree that it would not be proper for an insurance company to "double dip" (recover in subrogation and then offset that recovery), we would want the insurance company to have the option to choose one or the other in determining how to integrate with third party settlement benefits. To this end, we suggested and the PSC accepted, the following language:

- as item (3) at the end of the SUBROGATION provision, item § 6.J. on page 46:

"(3) If a certificate includes both this subrogation right and the right to reduce benefits or income on account of any amount received from third party settlements, the certificate shall state that, with regard to any specific claim, if the insurance company elects subrogation, the insurance company will not be permitted to reduce a *Disability* benefit on account of other benefit or income by any amount received from any third party settlement for that same claim."

- §9 (B)(1)(m)(ii), on page 53:

"If the certificate includes both this right to reduce benefits or income on account of a third party settlement and a subrogation right, the certificate shall state that, with regard to any specific claim, if the insurance company elects to reduce a *Disability* benefit on account of other benefits or incomes for any amounts received from any third party settlements, the insurance company will not be permitted to elect subrogation for that same claim."

The CAC letter asserts that the IIPRC's PSC has failed to provide a high national standard of consumer protections, and that such failed effort has exposed a gap in NAIC policy guidance for state insurance department policy form review. We respectfully disagree with this assertion.

First, the 44 members of the IIPRC and IIPRC staff have worked diligently for the past year to review and discuss the proposed standards and ensure that such review was thorough and detailed. IIPRC staff spent countless hours researching citations and state filing records to substantiate comments. In the absence of an NAIC Model specific to Group DI products, the 8 standards that have been developed and proposed for adoption represent a significant effort to document Group DI requirements, definitions, provisions, and benefits that have never been documented before, and include what we all consider a level of consumer benefits/protections at least equal to or greater than those that existed before. While there may be disagreement on one offset in the standards, this does not justify an unfair criticism of the IIPRC's efforts.

Second, when regulators recently met to discuss the future of the Accident & Sickness Model, and whether DI sections therein should stay, or whether a separate Model was needed for them, several regulators advised that since the IIPRC has already developed Individual DI standards and was soon to adopt Group DI standards, consideration should be given to rely on these and not develop a new Model. ***We don't believe that this would have been the case if the standards that had been adopted or those under development scraped the bottom of a barrel with respect to consumer benefits/protections.***

The CAC letter complains about third party tort recovery inadequacies, and the absence of an NAIC Best Practices Whitepaper or Model to provide guidance to assist state insurance departments in reviewing group disability income insurance forms. Both of these issues are technically outside the scope of the IIPRC's jurisdiction and, accordingly, were not addressed in the development of the Individual or Group DI standards.

In summary, subrogation and an offset are very distinct concepts and it is erroneous and misleading to equate these and imply that Group DI insurance contracts with offsets need to comply with state subrogation laws, specifically "made whole" laws, when this has never been the case. Accordingly, contrary to what the CAC letter contends, the proposed standards do not ignore or destroy long established consumer protections related to this issue.

§3. TERMS AND CONCEPTS

Item (22) "Elimination Period", Page 14

We had previously requested that accumulated vacation leave be integrated with the Elimination Period, as is frequently requested by employers. We continue to fail to understand how the PSC is willing to allow integration with personal time off, salary continuation or sick leave, but not with accumulated vacation leave.

We respectfully request that the PSC reconsider why it is making the distinction for accumulated vacation leave.

§4. REQUIRED PROVISIONS, Q. Termination of Insurance Under the Policy, Item (1) (b)(ii), Page 35

For consistency with item (b)(iv) on page 36, we suggest that the language change to say: "by giving the policyholder a specified period (such as 31 days) of advance written notice if less than:".

§9. BENEFIT PROVISIONS, Item ((1)(m)(i), Third Party Settlement, Page 52

We have serious and practical concerns with the words "the Company [this should say the "insurance company"] shall estimate the amount by using a percentage of the settlement amount based on the *Covered Person's Pre-Disability Earnings*, prorated to cover the period for which the settlement or judgement was made;".

First, all group DI monthly benefits are based ***on a percentage*** of a Covered Person's Pre-Disability Earnings, such as 40%, 50% or 60% which is the most common. Employers would never ask for a benefit equal to 100% of *Pre-Disability Earnings* and insurance companies do not provide it – too costly and eliminates any incentive to return to work. Accordingly, the reference to "*Pre-Disability Earnings*" in the proposed language is not appropriate.

Second, we believe that the recommended process to "estimate by using a percentage of the settlement amount" would result in calculations that would lead to a dispute on every such claim.

Accordingly, we offer the following alterative for your consideration:

"(i) if the amount received from a third party does not specify the lost income amount, the insurance company shall subtract from the settlement amount the legal fees and the *Covered Person's* out of pocket medical expenses amount and apply the remaining settlement amount as an offset against the disability income benefit payments over the same period for which disability income benefits are payable under the certificate. If the *Covered Person's* out of pocket medical expenses are not included or identified in the settlement amount, the *Covered Person* shall provide the insurance company with a documentation of those expenses. If the *Covered Person* fails to provide such

documentation, the insurance company shall offset the settlement amount without regard to the *Covered Person's* out of pocket medical expenses."

(H) COBRA INSURANCE PREMIUM BENEFIT, Item (4), Page 63

The original draft for this benefit included a NOTICE that would be included in the certificate. The PSC initially rejected the NOTICE but subsequently agreed to include it, but made it "The ***policy*** may include". There is no statement that the NOTICE may also be include in the certificate. The PSC discussion notes explain that, since the IIPRC staff knows that whatever is in the policy may also be included in the certificate, there is no need to address the fact that the NOTICE may also be included in the certificate. We disagree.

We respectfully request that a 7 word sentence be added to the end of the item stating that; "The certificate may also include the notice." We believe that because the standard only refers to the policy and is silent about the certificate, and because today's practice is to include this notice in the certificate, that it would be beneficial to all to include the 7 words. Doing so will eliminate the guesswork and questions.

Re: Initial Rate Filing Standards:

§2. ADDITIONAL SUBMISSION REQUIREMENTS

In the development of the group rate standards, there were no "standards" on which to base a group draft, so the IIPRC individual DI standards were used as a starting point. Unfortunately, at that time industry did not have enough actuarial representation to weed out those requirements not applicable or appropriate to group DI products. During the 60 days review period, we were able to engage more company actuaries and the result is that they found more rate requirements that are not applicable/appropriate for group DI, and are not included in rate filings today.

With all of the suggested changes below, we are not sure whether an Appendix is needed for Initial Rates and/or Rate Revisions standards, and if one is still needed, we are not sure what it should include. After the IIPRC reviews the comments, we will have a better picture of what is needed and we would be willing to assist in finalizing this. We do suggest that if an Appendix is needed, that it be named "Appendix A" for each standard (the current Rate Revision one now is now named Appendix A-1").

Item B. (1)(e)(ii), Page 3

Voluntary termination is not an assumption included in group insurance rate filings today – this is more appropriate for individual DI rate filings. Group coverage in general, as well as for DI, is provided to any and all eligible members of the group. If an individual joins a group, they would become covered as soon as they meet the applicable eligibility requirements. Conversely, if the individual ceases to be eligible under the group policy, such as termination of employment, that individual would no longer be covered. When companies price on an attained age basis, it does not matter to them when individuals come and go. When companies price on an issue age basis

(generally individual coverage), the level nature of the premiums exceeds the cost of insurance in the early policy years and is less than the cost of insurance in later policy years, and therefore the issue of termination assumption for the individual insured is very important as it can be a key source of margin (or lack thereof) in the pricing. This is not something companies have to worry about in group coverage, as well as DI group coverage.

We suggest that this item be deleted.

Item B. (1)(e)(vi), Page 3

Distribution of business is not an assumption included in group insurance rate filings today, and the companies are not quite sure how they would comply with this requirement – how are companies expected to respond to this? We believe that this is another individual DI requirement. Group DI policies are written to cover all eligible employees.

We also note that "distribution of business" is mentioned in item (f)(ii) on page 3 and whatever is decided for (e)(vi) will also affect these references.

We believe that references to "distribution of business" should be deleted.

Item B. (1)(e)(vii), Page 3

The companies wanted it noted that with regard to commission, expenses and profit, these would vary significantly by case size (number of lives in a group). Companies that write large cases would have much lower expenses and commissions. Companies that write smaller cases would have much higher commissions and expenses. The group DI insurance companies can change their case mix over time and thus deviate from these amounts.

Item B. (1)(f)(i), Page 3

The reference to "policy form" in this item needs to change as follows:

"(f) a description of the supporting documentation for the determination of the Minimum Loss Ratio (MLR) applicable to the average annual *Premium* per *Covered Person* under the policy."

The reference to "policy" in sub-item (i) is OK.

Item B. (1)(f)(ii), Page 3

In line with the comments made for (f)(i), the references to "average annual *Premium* for the policy form" and "average annual policy *Premium*" need to be changed to say: "average annual *Premium* per *Covered Person* under the policy."

Item B. (1)(f)(iv), Page 4

We suggest that this item be revised to state: "The discount rate and the average annual *Premium* per *Covered Person* under the policy."

The MLR information was addressed in item (f) on page 3.

After it is determined if we need an Appendix, it can be decided if the information to be provided will be shown in the Appendix.

Item B. (1)(g), Page 4

We suggest that the last two sentences in the item be deleted. The companies advise that active life reserves are individual DI requirements that are not applicable to Group DI, and the companies have never been required to provide this type of information for group DI filings. Additionally, §2.B (1)(f) does not discuss pricing, so the reference back to this item is not appropriate.

Item B. (1)(h), Page 4 and Appendix A, Page 6

We suggest that this entire durational loss ratio item be deleted.

We previously argued to shorten the 20 year requirement to 3 years, but the companies now agree that since group DI is an annual renewable product, there is no durational loss ratios, and such ratios have never been required in group DI rate filings.

We also note an inconsistency here in that item 2.(B)(1)(g) on page 4 defines ALR as the PV of benefits to the PV of premiums, and the ALR is defined in the Appendix where Incurred Claims are defined as "change in reserve plus claims paid".

Re: Rate Revision Filings Standards:

§2. ADDITIONAL SUBMISSION REQUIREMENTS

Item B. (1)(e)(ii), Page 3

As stated above for initial rate filings, voluntary termination is not an assumption included in group insurance rate filings today – this is more appropriate for individual DI rate filings. We suggest that this item be deleted.

Item B. (1)(e)(vi), Page 3

Distribution of business is not an assumption included in group insurance rate filings today, and the companies are not quite sure how they would comply with this requirement – how are companies expected to respond to this? We believe that this is another individual DI requirement. Group DI policies are written to cover all eligible employees.

We also note that "distribution of business" is mentioned in item (h) on page 3 and whatever is decided for (e)(vi) will also affect this reference.

Item B. (1)(e)(vii), Page 3

The companies wanted it noted that with regard to commission, expenses and profit, these would vary significantly by case size (number of lives in a group). Companies that write large cases would have much lower expenses and commissions. Companies that write smaller cases would have much higher commissions and expenses. The group DI insurance companies can change their case mix over time and thus deviate from these amounts.

Item B. (1)(h), Page 3

The references to "average annual Premium" and "average annual policy *Premium*" need to be changed to say: "average annual *Premium* per *Covered Person* under the policy."

Item B. (1)(i), Page 3
Item B.(1)(k), Page 4

The companies advise that for an issue aged product where the premiums are level for the lifetime of the policy it makes sense to evaluate the resulting experience vs. the original assumption. However, group DI products are priced with a 1-3 year rate guarantees. The premiums change as the demographics change. The mix of business by case size or other characteristics change over time thus the target loss ratios change. Expenses change. Technologies change. Marketed policy language/provisions change. We believe that all of these changes render the ALR irrelevant. Accordingly, we suggest that the items be deleted.

Item B.(1)(m), Page 4

Since we are recommending the deletion of item (k), we suggest that the companies would be willing to provide 3-5 years of experience to support a requested rate revision, to include premiums, premiums adjusted to proposed rate basis, number of claims, incurred claims, loss ratio, adjusted loss ratio, target loss ratio, actual to target, proposed actual to target. Premiums, claims and expenses should be adjusted to a basis consistent with the revised pricing assumptions to demonstrate the reasonability of the revised rates.

This type of requirement could become item (m) and the information requested could be provided in a format described in a revised Appendix A.

Item B.(1)(n), Page 5

We have already advised that we believe that for group DI products the ALR is irrelevant for rate increase filings. We also believe that justifications should be provided with any and all proposed revised premium rates, and not just in situations where the LFLR is less than the LR. We suggest that this item be changed to say:

"A justification and supporting documentation for the use of the proposed revised *Premium* rates."

Submitted by the Industry Advisory Committee:

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